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Meet the Presenter…

Brandy Brimhall, CPC, CMCO, CCCPC, CPCO, CPMA

On the topic:
How Payable Are Your Claims?
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Practice Management Institute®
8242 Vicar | San Antonio, Texas 78218-1566
tel: 1-800-259-5562 | fax: (210) 691-8972
info@pmiMD.com
How Payable and Compliant Are Your Claims?

Brandy Brimhall  CPC, CMCO, CCCPC, CPCO, CPMA

“Take the same notes that you’ve taken for the past x# of years. Continue to study the fundamentals.... As soon as you skip that part, you are cheating yourself and your team and not performing at the level you need to be at.”
Why You Really Document & Code

Get Paid

Risk: MAX

Risk: MIN
Tell the story

7 Elements of a Payable Claim

- Care was Medically Necessary
- Services Were Provided
- No Statutory Violations
  - For example: Stark Law, federal anti-kickback, False Claims Act, etc.
- Meets all coverage rules
- Fully Documented
- Properly Coded
- Properly Billed
Learning the Language

- Service Codes say "What" you do
- Diagnoses Codes say "Why"
  - Must always say 'Why’ to validate your ‘What’ (diagnose your services)

Communicate in Detail

- Modifiers add increased specificity to services
Being Confident with Coding

- Know how to find answers
- Be proactive, not reactive
- Use reference materials
- Seminars, webinars, books, manuals, etc
  - Even a review is good
- Utilize your other resources
  - Local organizations
  - Payers (Medicare, etc)
  - People

Common Coding & Billing Risk Areas
Common Risk Areas

- Billing for non-covered services as if covered (code changing for the purposes of payment only)
- Incomplete Medical Records
- Records don’t indicate measurable functional improvement of patient condition

More Risk Areas

- Treatment history reveals patients have received treatment for several months or even years
- Little to no documentation supports necessity of treatment
  - Carefully evaluate treatment goals, must ensure adequate pain assessment is recorded as well as continued care assessment, etc.
Common Risk areas Continued

- Is there evidence of improper waiver of copayments and/or deductibles from patients?
- Is there evidence that the Dr is providing free or discounted services to referral sources or to patients in an effort to induce referrals?
- Improper use of ABN forms
  - Including absence of written protocol for patients who refuse to sign ABN

Continued...

- Signatures or dates-of-service are not included on treatment notes
- Level of subluxation is not identified
- Chief complaint when identified does not correlate with subluxations/area of treatment (per Medicare req)
- Treatment Plans missing, incomplete or not individualized
- Frequent, long term visits with no support for continuation of treatment
- No evidence of improvement after long periods of care
Establishing Proper Billing Systems

Many Moving Parts

- Patient care
- Patient scheduling
- Documentation
- Coding
- Billing
- AR
- Compliance
- ...

Revenue Cycle
The Revenue Cycle System

- Claims Scrubbing
  - CPT/PCS, ICD-10, Modifiers, review
  - Correct and current claim detail
- Claim submission
- Rejection management
- ERA/EOB review and posting
- Follow-up and appeals
- Accounts Receivable evaluation and management
- Dr and CA communications

Patient visits/care & Revenue Cycle... makes up the Nervous System
Dysfunction or Interference

Affects one or more parts of the system and over time, possibly the system as a whole

How Dysfunction Happens

- Single gatekeeper
- Baton Passing
- Insufficient or absent training
- Challenges with time management or time availability
- Lack of awareness of the value of Revenue Cycle Systems
- Guessing or taking advice through the grapevine
- Inefficient billing, collections and AR systems
CAN YOU RELATE?

TAKE A LOOK AT YOUR BILLING SYSTEMS
Claims Submission Considerations

- Submission of clean claims
  - Should be double checked internally prior to submission
  - Automatically sending claims without viewing them ensures there will be mistakes that could be avoided

- Know the limitations of a clearinghouse

- Those doing data entry and billing should have continued education on coding and documentation guideline
  - Doctors too!!

In submitting this claim for payment from federal funds, I certify that to the best of my knowledge and belief, the information on this form is true, accurate and complete. I have familiarized myself with all applicable laws, regulations, and program instructions, which were available from the Medicare contractor. I have provided or will provide sufficient information required to allow the government to make an informal eligibility and payment decision on this claim, whether submitted by me or on my behalf by my designated billing company, comply with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-Kickback statute and Physician Self-Referral law (commonly known as Stark law) if the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE. For each service rendered incident to my professional service, the identity (legal name and NPI, if any) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bill.
### Service Line Information

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<th>Service Date</th>
<th>Rendering NPI</th>
<th>Paid Units</th>
<th>Proc/Rev Code/ Mod</th>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Deduct Amount</th>
<th>Copay Amount</th>
<th>Late filing</th>
<th>Adjusts</th>
<th>Adjusts</th>
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**SERVICE LINE TOTALS:**

- **$250.00**
- **$95.00**
- **$0.00**
- **$0.00**
- **$0.00**
- **$185.00**
- **$155.00**

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234. This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the HCPCS reject reason Code, or Remittance Advice Remark Code that is not an ALERG.)

Star: 01/24/2010

PR-40: Charge exceeds fee schedule/maximum allowable or contracted/deducted fee arrangement (Use only with Group Codes PR or CD depending upon liability)
<table>
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<tr>
<th>Service Date</th>
<th>Provider Code</th>
<th>Actual Amount</th>
<th>Allowed Amount</th>
<th>Adjust Amount</th>
<th>Codes Adjusted</th>
<th>Late Filing Rate</th>
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**SERVICE LINE TOTALS:**
- Total: $30.00
- Adjusted: $30.00
- Adjusted: $30.00
- Adjusted: $30.00

**Note:** This document contains medical billing information. It is important to review the policies and guidelines provided by the relevant healthcare organizations before submitting claims. Any discrepancies or questions should be addressed with the provider or billing department. Ensure all required documentation is included with the claim to avoid delays in processing. Always check the policy guidelines for the most accurate information. **Disclaimer:** This information is for general use only and may not be applicable in all situations. The provider is responsible for ensuring all claims are submitted according to the organization's policies.
Controllable Errors

Make Adjustments to Avoid Controllable Errors, such as, but not limited to:

- A clinic error that includes exceeding insurance limits
- No authorization for a specific date of service
- Using codes that are not authorized by an insurance company
- Improper use of modifiers
- Insufficient diagnosis pointing
- Insurance expired before the patient’s visit
- Not collecting co-pays, coinsurance and deductibles at the time of service
- Chart notes not available for a specific date of service
- Delivering care for a patient with insurance that you do not accept
- Know network details, payor policy details and patient policy details (verification)

Payors have individual rules

- Medicare
- Medicare Advantage
- WC/PI
- Standard Major Medical
Coding and Claim Form ‘Yellow Flags’

- Date-of-Current is often left unchanged
  - Box 14
  - PI/WC won’t change

- “Cookie Cutter” coding/billing
  - Could be on an individual patient or on multiple patient claims that are identical

- Over consistent use of codes
  - Ex. 98941 on every patient visit
  - Ex. 99203 on every new patient
Continued

- Diagnoses pointing the same for every service
- No use or unusual use of modifiers
- Excessive billing of multiple units for services

Continued

- Inappropriate use of codes that should not or cannot be used together
  - Ex. 99211 & 98941
- Unusual or created codes appearing on claim forms
  - Example: 00000 or 99999
- Diagnoses not listed to support services
  - May indicate specific services were not rendered or possibly not necessary
**Mis-used or Under Used Codes**

- Exams (99201-99205, 99211-99215, etc.)
- Extremities (98943)
- Other therapies
  - 97140
    - Must be performed in a separate region
    - Manual means “hands-on”
  - 97112
  - 97026
- CMT Services (98940-98942)
  - Medicare requires subjective detail
  - Diagnoses often don’t support the service billed

**Using Internal Codes**

- Use of internal codes creates obstacles
  - Not able to be interpret outside of the practice
  - Sale of practice or vacation relief
  - May be ill defined
- CPT, HCPCS Code sets will generally have appropriate code
  - If not, “unlisted” codes are available
- Common examples for internal codes that are available elsewhere:
  - S9999 = Sales Tax
  - S9982 = Medical Records Copy Fee
Claim Form “Yellow Flags”

- Unusual use of diagnoses codes

Working Outside Scope of Practice

Claim Form “Yellow Flags”

- Inconsistent or multiple fees for individual services
- Using the same diagnoses to point to the same service